

Alcohol, Tobacco and Other Drug Use by Addictions Professionals: Historical Reflections and Suggested Guidelines

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Abstract

Alcohol, tobacco, and other drug (ATOD) use by individuals working in the addictions field has existed as a complex, controversial personal and professional practice issue for more than 150 years. The central debate within this history involves the concept of nexus—the boundary that distinguishes rights to personal privacy from professional duties and obligations. Ambiguities related to this point of demarcation have contributed to misjudgments related to ATOD use by addictions professionals that have injured multiple parties. This essay reviews the history of ATOD use as a professional practice issue in the addictions field; discusses clinical, ethical, and legal issues related to ATOD use by addiction service professionals; and offers guidance on ATOD use decision-making.

Introduction

I entered the addictions field in the 1960s as a “streetworker” and aspiring “drug abuse counselor” at a time when few guidelines existed concerning the alcohol, tobacco, and other drug (ATOD) use decisions of service practitioners. Nearly forty years later, ATOD-related decisions remain an ambiguous and conflict-ridden area of personal/professional decision-making for preventionists, counselors, and others who work in the addictions field. Personal misjudgments within this arena have injured and ended careers, injured the reputations of addiction treatment institutions, and created a perceptual barrier that prevented individuals and families from seeking needed services.

In spite of its potential importance and its connection to the central mission of the field, ATOD use has existed only in the shadows of professional practice discussions. The subject is rarely broached inside service organizations and invisible in the field’s professional journals and conferences. Knowledge of staff who have been disciplined or discharged for ATOD-related behavior and the circumstances surrounding such actions exist primarily in the arena of whispered gossip. And one of the most important of these issues—smoking as a professional practice issue for addictions professionals—is approached primarily through heated debates about organizational smoking policies. The time for more open and far-reaching discussions of ATOD-related decision-making by addictions professionals is long overdue. This article:

- 1) reviews the history of ATOD use and related problems as a professional practice issue in the addictions field;
- 2) defines ethical, legal, and clinical issues that arise in response to the ATOD-use decisions of addictions professionals; and
- 3) offers guidelines for addictions professionals related to ATOD-use decision-making.

The focus of these discussions will be on the ATOD-related decision-making of the individual who works in the field, rather than the broader policies that addiction treatment organizations should adopt related to such use. The guidelines set forth here are humbly and respectfully submitted with full awareness that others of good faith and deep commitment to the addictions field will view some of these issues differently.

A Historical/Personal Retrospective

Early History

The earliest recovery mutual aid societies span eighteenth and nineteenth century Native American “recovery circles,” the Washingtonian revival of the 1840s, recovery-focused fraternal temperance societies, the ribbon reform clubs, local recovery societies (e.g., the Drunkard’s Club, the United Order of Ex-Boozers), and institutional aftercare groups (Keeley Leagues, Godwin Association) (White, 1998). Members of these organizations reinforced their own commitment to sobriety by performing rescue work with other alcoholics and by serving as temperance speakers and organizers. In these societies, personal recovery was viewed as an essential credential for reaching out to others who were addicted.

For the reformed inebriate knows each avenue to his brother’s heart; he highly touches the string on which hangs all his sorrow; no rebuke mingles with his invitation of welcome... (Woodman, 1843, p. 95).

Two problems arose within this early history. The competition between reformed men making public temperance speeches led to exaggerations and outright fabrications. Exposure of such mistruths, in a process remarkably similar to the recent controversies surrounding James Frey’s *A Million Little Pieces*, discredited the larger recovery movement of that period (White, 1998). A second problem was the relapse of reformed men who had become well known temperance lecturers/missionaries (White, 2000a). Men like Edward Uniac and Luther Benson, who tried to find sobriety on the temperance lecture circuit, suffered highly publicized relapses. Uniac died of an overdose of whiskey, bromides, and opium while on a temperance lecture tour in Massachusetts, and Benson drank his way into the Indiana Asylum for the Insane (Benson, 1896; Berry, 1871). Like many of his peers, Benson had thought that throwing himself into temperance work would quell his own appetite for alcohol.

I learned too late that this was the very worst thing I could have done. I was all the time expending the very strength I so much needed for the restoration of my shattered system (Benson, 1896, p. 128-129).

Even John Gough, the most successful of all the nineteenth-century recovery missionaries, experienced several early relapses after beginning work as a temperance speaker (Gough, 1870). The public downfall of some of these early leaders reinforced the ways in which seemingly private behavior could discredit sobriety-based social movements.

The American Temperance Movement exerted an enormous influence on the rise of addiction treatment in the United States. The therapeutic branch of that movement performed rescue work with drunkards and advocated the creation of special institutions for the moral and medical care of the drunkard. All of its members had signed a personal pledge of abstinence before embarking on their rescue work. That influence also shaped the expectation that those working in early inebriate homes and asylums, addiction cure institutes, rescue missions, and inebriate colonies would model the sobriety they were helping others achieve (White, 1998).

In such an abstinent environment, even a past history of addiction could call into question one’s ability to work in treatment institutions. A debate raged between the branches of the field on this question, with inebriate homes and some addiction cure institute leaders advocating that personal reform constituted a valuable credential in providing moral uplift for the drunkard, while leaders of the more medically oriented inebriate homes and asylums suggested that past addiction disqualified one for such work. Dr. T.D. Crothers argued this latter position with great passion in editorials that appeared in the *Journal of Inebriety* in the closing years of the nineteenth century.

It is confidently stated that a personal experience as an inebriate gives a special knowledge and fitness for the study and treatment of this malady. While a large number of inebriates who have been restored engage in the work of curing others suffering from the same trouble, no one ever succeeds for any length of time or attains eminence...Physicians and others who, after being cured, enter upon the work of curing others in asylums and homes, are found to be incompetent by reason of organic defects of the higher mentality...The strain of treating persons who are afflicted with the same malady from which they formerly suffered is invariably followed by relapse, if they continue in the work for any length of time (Crothers, 1897, p. 79).

While there is evidence that some early addiction treatment practitioners suffered relapses resulting in death or disengagement from the profession (White, 2000c), these events appear to be the exception to otherwise significant contributions by recovering people working as physicians and managers within early inebriate treatment institutions.

The Middle Years

The debate over the question of alcohol and drug use by the addictions professional died in the early twentieth century in the larger collapse of addiction treatment as a professional field. As the larger field faded into obscurity, local experiments in addiction treatment continued, the most significant of which were the lay therapy movement started in Boston and the brief spread of morphine maintenance clinics. The roots of the lay therapy movement can be traced to Boston, where the leaders of the Emmanuel Episcopal Church established a clinic to treat nervous and mental disorders via the integration of religion, psychology, and medicine.

Rapidly developing a specialty in the treatment of alcoholism, the Emmanuel Clinic developed techniques to treat alcoholics and to then recruit and train some of those treated as lay alcoholism psychotherapists. Individuals such as Courtenay Baylor, Francis Chambers, Samuel Crocker, James Bellamy, William Wister, and Richard Peabody were treated within this lay therapy tradition and went on to long, often distinguished careers as lay therapists (White, 2000b).

The continued abstinence of the lay therapists was a cornerstone of their work, as disclosure of their own recovery stories and recovery maintenance strategies was central to their approach to alcoholism therapy. The precise support mechanisms used by these lay therapists to sustain their recoveries is unclear. There was a support structure available (the Jacoby Club), but there is no evidence that the lay therapists participated in the Club. Problems of relapse among some of the lay therapists (Wister, Crocker, McKay, and Peabody) raised questions about the potential to replicate lay therapy broadly across the country (McCarthy, 1984), but this role was sustained through the 1940s, 1950s, and 1960s (by such noted lay therapists as James Lamb Free) and constitutes an important precursor to modern addiction counseling (Anderson, 1944; White, 1998).

Very little is known about those working in the morphine maintenance clinics that briefly flourished between 1919 and 1924, although there is evidence that Dr. Charles Terry, one of the pioneers of the morphine maintenance clinics, developed severe alcohol-related problems later in his career (Courtwright, 1986). Terry's experience illustrates one of the anomalies of the addictions field: the vulnerability of those who work in the field to develop ATOD-related disorders. Whether this is a result of the attraction of those with increased vulnerabilities to the field, or of some contagious element activated by sustained exposure to the field, remains a question of some speculation. What is clear is that the ATOD-related impairment of service professionals within the field has long served as a stain on the field's professional and cultural credibility (White, 1998).

Multiple service roles followed the founding of Alcoholics Anonymous (AA) in 1935. Sponsorship evolved within AA in the early 1940s, and AA members who were physicians and nurses worked within newly opening "AA Wards," "AA Farms," and "AA Retreats" (Anonymous, 1952). Such roles became more formalized in the emergence of the Minnesota Model in the late 1940s, with the State of Minnesota establishing a "counselor on alcoholism" civil service title in 1954. The spread of this model and the continued lay therapist role within new experiments with outpatient alcoholism clinics set the stage for the emergence of the modern alcoholism counselor role (White, 2000b).

This emergence was marked by considerable debate over the question, "Who is qualified to treat the alcoholic?" What became known as the "Krystal-Moore debate" characterized the poles of this controversy. Dr. Henry Krystal argued that only the psychoanalytically trained psychiatrist was equipped to treat the alcoholic and that the lack of such training rendered one ineffective and potentially dangerous. Dr. Robert Moore took the opposing position that individual psychotherapy was not the treatment of choice for alcoholics, and that lay counselors, if supervised by professional psychotherapists, could provide effective support for recovery initiation (Krystal & Moore, 1963). One of the wise leaders of the modern treatment field characterized this prolonged debate as "noisy emotional outbursts launched from shaky premises on both sides" (Ottenberg, 1977, p. 56). Significant for our current discussion is the fact that neither Krystal nor Moore identified past addiction or present abstinence as a critical qualification for those treating people addicted to alcohol (McGoldrick, 1964).

The rationale for the training of those in recovery to serve as alcoholism counselors was that they could offer living proof of the transformative power of recovery, serve as role models of sobriety-based problem-solving, establish empathy and communication with alcoholics who bristled at professional authority, and help orient clients to the program of Alcoholics Anonymous (Blume, 1977). It was through these roles that personal abstinence and recovery served as a credential in the gestation and birth of alcoholism counseling as a profession. At the same time, it created early ambiguity and conflict related to the delineation of the roles of A.A. sponsor and lay therapist (counselor).

Modern History

My own personal/professional history reveals the evolving ambiguities and contradictions related to ATOD use by addictions professionals in the modern era. I entered the addictions field at a time it was really two fields: an alcoholism field and a drug abuse field. I worked with a foot in each of these fields as a self-identified “ex-addict” whose beliefs were shaped most heavily under the tutelage of Gateway House, an early therapeutic community (TC). At Gateway, like most of the TCs of this period, drinking was accepted and even promoted to clients via earned drinking privileges, and occasional social drinking was the norm among TC staff. Alcohol was simply not seen as a “drug.” The growing prevalence of alcohol problems among “ex-addict” staff slowly altered that perceptual blindness.

A symbolic event marked the field’s need to end its segregation between alcohol and drug camps. In 1978, Charles Dederich, the founder of Synanon—the first ex-addict-directed therapeutic community (Janzen, 2001)—was arrested. The scene of Dederich being carried in a state of extreme drunkenness into police custody (for charges of conspiracy to commit murder) constituted vivid testimony of the flawed dichotomization between alcoholism and addiction treatment and recovery. Dederich’s plummet from power offered convincing testimony that professional pioneers, through their own personal decisions and behaviors, could wound the very fields they had earlier nurtured into existence.

Persons recovering from alcoholism were the mainstream workforce of the alcoholism programs of the 1960s and 1970s that were spawned by funds from the Office of Economic Opportunity (OEO), the National Institute on Mental Health (NIMH), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). These programs grew explosively in the early 1970s at a time when few guidelines existed on how to recruit, select, orient, train, and supervise recovering people, who were then branded as “paraprofessionals.” Fueled by a growing body of knowledge suggesting the potential effectiveness of peer-facilitated models of change (Riessman, 1965; Durlak, 1979; Hattie, Sharpley & Rogers, 1984), particularly within the arena of addiction recovery (Brown & Thompson, 1976; Longwell, Miller, & Nichols, 1978; Connett, 1980)¹, recovering people with little sobriety time were thrust into positions characterized by low pay, poor role definition, and excessive demands for time and emotional energy.

Concerns about the relapse of counselors grew as this “new profession” came of age (White, 1979; Kinney, 1983; Wilson, 1984). That many recovering people went on to become leaders within this field under such circumstances is testimony to the transformative power of recovery that masked the casualties of many of their peers. The growing consciousness of such casualties led to the expectation that those first certified to work in the field would have “no history of alcohol or drug misuse for a minimum of two years immediately prior to certification” (From the 1974 Littlejohn Report, Quoted in Blume, 1977, p. 563). Recovering people working as alcoholism counselors were expected to have two-to-five years of stable sobriety and sustain their sobriety through “working the program”—active involvement in A.A. or Al-Anon (McInerney, 1973).²

With the rapid diffusion of methadone maintenance treatment (MMT) in the late 1960s and early 1970s, methadone-maintained counselors were caught in a purgatory of conflicting messages. Clinic doctors defined methadone as a life-saving medicine, while professional critics, social activists, friends, family members, and former-addict peers often characterized methadone as a “technological fix,” a substitute high (“poor man’s heroin”), a genocidal poison, or a confession of street incompetence (e.g., “methadone is for losers”). The low-dose policies and scarcity of recovery support services in MMT clinics of this era generated high relapse rates and high rates of secondary drug use. Alcohol problems and relapse to opiate addiction were common occurrences—among clients and staff. The highly stigmatized status of methadone left the lives of many methadone clients and methadone-maintained staff hiding their “dirty little

¹ Such studies have continued. See Aiken, LoSciuto, Ausetts, & Brown, 1984; Blum and Roman, 1985; Galanter, Castaneda & Salamon, 1987; McGovern & Armstrong, 1987; Stoffelmayr, Mavis & Kasim, 1998)

² Sobriety requirements changed during this early history, with the early OEO alcoholism programs of the 1960s requiring only one year of sobriety for their counselors.

secret”—a status that remained in the decades that followed, in spite of overwhelming scientific evidence of the effectiveness of MMT (Murphy & Irwin, 1992).

The polydrug counterculture of the 1960s generated its own brand of folk healers and service workers via the emergence of crisis and drop-in centers (including “acid rescue”), free clinics, rock festival medicine, drug-testing services, outreach (“streetwork”) programs, outpatient counseling clinics, and “crash pads.” Drug use by those working in these institutions was seen more as a badge of cultural membership than a breach of ethics, although there was an emerging etiquette about not “holding” while you were at the service facility and not being “stoned” or “tripping” during your shift. The line between service provider and service recipient was a fluid one in this world, with many individuals cycling in and out of both roles. A core of these early workers matured out of such use; migrated into structured programs of recovery; or attempted, not always successfully, to continue drug use (e.g., smoking marijuana) in secret.

As money flowed into the field in the 1970s and 1980s and the field became a less stigmatized professional arena, growing numbers of psychiatrists, psychologists, social workers, and business entrepreneurs arrived. Some were drawn to the field’s frontier status. Others were drawn to the field to work out their own problematic relationships with alcohol and drugs or to sort out having survived families with such problems. Consciousness of, and contradictions related to, such problems were magnified when addiction services were integrated into the traditionally heavy drinking cultures of mental health and criminal justice institutions in the 1960s and 1970s.

The diverse populations that made up the addictions workforce in the 1970s did share one thing in common: daily rituals of massive nicotine and caffeine consumption. The full spectrum of ATOD use was most evident at the field’s early state and national conferences. In the evenings at such conferences, workers in recovery clustered within Twelve Step meetings filled with tobacco smoke and caffeine-fueled exchanges of experience, strength, and hope. Outside those meetings, heavy drinking was the norm, and the pungent smell of marijuana in the hallways of conference hotels was common.

That abstinence-based treatment philosophies emerged from such polypharmacy is itself an irony of history, created in good part by the influence these early groups exerted on one another. The growing integration of alcoholism and drug abuse programs within what was then called “combined treatment,” and the eventual larger integration of the two fields into one³, brought new ethics and etiquette surrounding alcohol and other drug use. There were several factors that contributed to this process, including the alcohol problems of ex-addict staff; the “pill” problems of some counselors in alcoholism recovery; the recognition of multiple drug use by a growing number of clients; the growing linkages between treatment programs, Alcoholics Anonymous, and Narcotics Anonymous; and the rapid professionalization of the role of addiction counselor.

As “recovery” took on a broader definition, many workers in the field shed “secondary drugs” or carefully limited their exposure to such substances. After seeing some of my ex-addict peers develop severe alcoholism, reviewing my multigenerational family history of alcohol/drug problems, and assessing my own relationship with alcohol, I joined many in the field who stopped drinking by choice or necessity long after we had defined ourselves as people “in recovery.” By the mid-1980s, the field had sobered itself under the influence of the “recovery movement” and a larger sobering of America that some christened the “new temperance movement.” The exception to this chemical shedding was the continuation of widespread nicotine and caffeine dependence among addictions professionals. Such dependence remained invisible as a professional and ethical issue, but this was about to change as well.

The addictions field reached a “tipping point” in the late 1980s and 1990s on the issue of nicotine, and excessive caffeine use moved into visibility as a personal and professional issue (Knapp, Rosheim, et al., 1993). It was during this decade that the addictions field and the larger culture began the painful process of redefining its perception of and relationship with tobacco. I stopped smoking in 1988 and shortly afterward terminated the last of my excessive chemical relationships (caffeine). The decision to quit smoking was prompted by individuals who confronted me about the incongruity between my role as a visible trainer in the addictions field and the behavior that I was modeling both to my professional peers and to consumers of addiction treatment services. I reached a point of consciousness that I simply could not continue in this field while in a state of active addiction. In the years that followed, controversies raged (and continue) over program smoking policies for clients and staff. The result was that a growing number of workers in the field, many of whom had for years touted their sobriety and clean time while chain-smoking cigarettes, began severing their relationships with this most lethal of drugs. Collectively, it was like blinders had been peeled off our eyes as we asked ourselves how we had for so long refused to define

³ The most intense period of this conceptual and organizational integration spanned the years 1975-1985.

nicotine as an addictive drug. It will take another decade for the attitudinal shift about nicotine to reach full fruition, but the die has been cast and is now irretrievable.

As the field began the process of painfully shedding its addiction to nicotine, it became a wetter field through an evolution in its workforce composition. The progressive escalation of educational credentials flowing from counselor certification and licensing standards reached a crescendo in the 1990s, pushing many recovering people out of the field and bringing many allied professionals into the field. This brought a higher proportion of people into the field who were alcohol users and a new generation of young people who were emerging from the binge drinking and new polydrug experimentation of the 1990s.

An interesting change in status occurred during the 1980s and 1990s for those working in the field with recovery backgrounds. Personal or family recovery experiences became a less desirable credential in the rush toward professionalization. The percentage of people working in the field in recovery declined, and those who brought such backgrounds referenced this status less frequently. There was in this move toward professionalization an implicit assumption that those working in the lay therapy tradition without formal, advanced academic credentials were somehow less effective in their clinical work with clients, but there was little evidence to support this assumption.

Studies comparing recovering and non-recovering addiction counselors concluded that recovering counselors are more likely to be older, to be male, to be less educated, to value recovery experience more than education, to feel more positively about their jobs, are to use a broader menu of treatment goals and techniques (McGovern and Armstrong, 1987; Blum & Roman, 1985; Stoffelmayr, Mavis & Kasim, 1998; Stoffelmayr, Mavis, Sherry & Chiu, 1999), but that they do not differ on critical performance measures. For example, no differences between recovering and non-recovering counselors were found related to such measures as client affiliation rates or post-treatment recovery/relapse rates (Machell, 1991; Brown & Thompson, 1976; Longwell, Miller & Nichols, 1978; Connett, 1980). A single study evaluating client perceptions of counselor backgrounds found that clients viewed those with more professional training as more trustworthy and expert regardless of recovery background (LoBello, 1984), and another found that clients of professionally educated counselors were more likely to be enrolled in educational programs following treatment than clients of recovering counselors who lacked professional education (Aiken, LoSciuto, Ausetts & Brown, 1984). One could read in the current proliferation of non-clinical recovery support roles (e.g., outreach workers, recovery coaches, personal recovery assistants, recovery support specialists) a backlash against the over-professionalization of the role of addiction counselor (White, 2004a). This latest shift is bringing a new generation of recovering people into service roles in addiction treatment and grassroots recovery advocacy agencies.

It is obvious from this brief summary that my motivations for writing this article are numerous: grief over the ATOD-related loss of professional peers, unabashed survival guilt, a desire to help a new generation of addictions professionals, and hope that I might contribute something of value to the ethics and etiquette of this most unusual and rewarding profession. Perhaps more than anything, I am weary of helping clients and colleagues celebrate their recoveries from addiction to alcohol, opiates, and stimulants, only to watch them later die premature deaths due to the consequences of nicotine addiction. I am also concerned about the addictions field's tenuous, probationary status within this culture and believe that anything that hurts the image of the treatment field—including ATOD-related incidents of its practitioners—contributes to the potential revocation of our legitimacy as a cultural institution.

As a field, we have entered the twenty-first century with the most diverse workforce in our history—a diversity that is again raising questions about what appropriate stance addictions professionals should take regarding their own ATOD-use decisions. For the foreseeable future, that decision-making will continue to take place within an evolving history filled with many contradictions and ironies. If one looked at this field from the outside in, a number of such contradictions would be puzzling.

- We are a field that historically has defined abstinence from certain drugs (e.g., alcohol, heroin) and dependence on other drugs (e.g., nicotine, caffeine) as criteria for in-group occupational status.
- Service professionals with AOD problems who are not self-identified as being “in recovery” face no length-of-sobriety requirements and may be hired and work without notice in the field until those problems affect their performance.
- Persons who self-identify as being in recovery face length-of-sobriety requirements not applied to other staff.

- Professionally credentialed counselors in recovery who withhold that recovery status may work in the field with less than minimum sobriety requirements, but could not do so if they were honest about their lengths of sobriety.
- People who experience and are treated for other health problems (including other behavioral health problems) may continue working in the addictions field as long as their problems do not affect their performance. Following treatment of other problems, they are allowed to return to work as soon as their physicians release them, but they may not do so following treatment of AOD problems.
- Addiction treatment programs promote employee assistance programs that recommend treatment as an alternative to terminating AOD-impaired employees, yet often do just the opposite with their own employees.
- There are programs that prohibit counselors from disclosing whether they are in recovery or not, yet demand to know the recovery status of each job applicant for a counseling position.
- There are programs that require evidence of pre- and post-hire participation in a particular pathway of recovery (e.g., Twelve Step meetings for those in recovery), but do not expect such participation for non-recovering staff.

As this discussion proceeds, we will try to explore the basis for such contradictions and the best ways of charting our path through this ill-marked and sometimes hazardous territory.

Defining Nexus: Rights to Privacy vs. Professional Duties and Obligations

Most addictions professionals would agree that there are spheres of their lives that are outside the arena of appropriate scrutiny by their employers and their professional organizations. Most would also agree that work in the addictions field brings duties and obligations that transcend the workplace and one's working hours. The troublesome question, therefore, is, "Where does one draw the line between rights to privacy and professional duties and obligations?" There is a substantial body of legal and ethical literature suggesting that an individual's private behavior is precisely that until there is a nexus—an inextricable connection—between private behavior and one's professional performance (White and Popovits, 2001).

Ethically speaking, the ATOD use of addictions professionals during non-work hours is not subject to professional scrutiny until that behavior harms their ability to perform professionally or otherwise inflicts harm to other persons or institutions. LeClair Bissell and James Royce, authors of the first ethics text for addiction counselors, argued that there was a clear nexus on the issue of personal alcohol/drug use.

If there are complaints that private life is just that and not the concern of the employer or colleague, it is quite fair to reply that, in this particular field, the use of chemicals and one's belief system about them is job related (Bissell & Royce, 1987, p. 10).

Before exploring specific case studies of ATOD-related professional practice issues, we will try to shed more light on this concept of nexus. Personal ATOD decisions are best filtered through some of the core values that have historically guided helping professionals (White & Popovits, 2001).

- The value of **obedience** dictates that addictions professionals adhere to the promises made to comply with laws and regulations governing their employment and their profession, e.g., compliance with ATOD use-related standards in personnel policies and professional codes of ethics linked to certification or licensure.
- The value of **competence** demands that addictions professionals not do anything that would compromise their professional decisions and behaviors, e.g., performing professionally while under the influence of alcohol.
- The value of **honesty** makes it incumbent upon addictions professionals to accurately represent statements they choose to make related to their ATOD use history and their recovery history and status.
- The values of **fidelity** and **loyalty** demand that addictions professionals maintain their fiduciary obligation to serve the needs of their clients and protect the integrity of their service organizations and the addictions field.

- The value of **non-maleficance** is a call to refrain from hurting anyone through the performance of one's professional role, e.g., injury of a client due to one's personal impairment.
- The value of **self-interest** recognizes the need for service professionals to protect themselves, both in terms of their physical/psychological safety and in terms of their professional reputation.

All of these core ethical values have potential relevance to situations involving ATOD-related decisions on the part of addictions professionals.

Another way to approach ATOD-related decisions is to ask oneself who stands to benefit and who could be injured by a particular ATOD-related decision. ATOD decisions constitute an arena of *multi-party vulnerability*. That means that multiple parties—the addictions professional, past/present/potential service consumers, the service organization, the larger professional field, and the community—could be injured by the addictions professional's ATOD-related decisions.

ATOD-related Professional Incidents

With this background laid, we will further explore how this nexus occurs between our private and professional lives. We will do this through brief vignettes drawn from the author's consultations on ethical issues that have arisen within treatment organizations around the country.⁴

1. **Substance-related Impairment of Performance During Scheduled Work Hours:** Raymond had worked as a counselor for two years within the addictions field prior to the day he arrived at work under the influence of alcohol. The resulting suspension and intervention led to his admission to alcoholism treatment and his subsequent decision to work outside the addictions field during his early recovery. Raymond's behavior illustrates one of the most direct ways in which one's personal relationship with alcohol or drugs, in this case a troubled relationship, can ripple into the arena of professional performance. Other cases involve less obvious effects on performance, e.g., missed work, feigned sickness due to hangovers or withdrawal, anxiety and depression, deterioration of clinical effectiveness.
2. **Substance-related Impaired Performance While "On Call":** Marybeth responded to an emergency call from a local hospital and felt that she had handled the situation just fine until the client's spouse filed a complaint that Marybeth was "reeking of booze" when she arrived at the hospital emergency room to conduct the interview. Marybeth's response was that she had consumed a beer with her dinner but suffered no impairment of any kind. The distinction between "use" and "impairment" are sometimes indefinable in such situations. Marybeth's behavior injured her own reputation and that of her agency. She was disciplined for violation of the agency policy related to consumption of alcohol while carrying a pager.
3. **Substance-related Deterioration in Self-care Responsibilities that Affect Professional Performance:** Fred tried to compensate for his increased drinking away from work by spending more hours at work as an intake worker at a treatment agency. The combination of increased alcohol intake, excessive work, and decreased sleep took its toll on his health and his performance. Ironically, the earliest sign of later troubles in this case was an increase in perceived productivity. A year later, everyone knew something was going on with Fred, but no one was sure what.
4. **Allegations of Substance Impairment:** After a sustained cold, Cathy received a prescription from her physician. Over the next two days at her job as an addictions counselor, Cathy became quite disoriented, giddy, and light-headed, and was forced to go home early on the second day. Several of the clients in treatment were whispering that Cathy was stoned. In another example, when Barry's clinical supervisor confronted him about what appeared to be substance intoxication, he acknowledged that he was taking a prescription for anxiety. Further investigation revealed that Barry had taken three times the prescribed dose.
5. **Substance-influenced Breaches in Relationships with Clients:** Lionel, an addictions counselor, resigned amidst allegations of financial and sexual exploitation of clients. A close review of his caseload revealed other simultaneous cases of clinical abandonment (service disengagement,

⁴ All names in these incidents have been altered.

fabrication of clinical contacts). Upon further investigation, it appeared that these behaviors followed on the heels of Lionel's relapse to cocaine addiction.

6. **Positive Random Drug Test:** Many addiction treatment agencies or units are governed by drug-free workplace policies that call for random drug testing. Robert had been viewed as an exemplary employee until he tested positive for cocaine on a random drug test. When another employee, Shandra, was called to take a random drug test, she reported that she had taken a prescription narcotic, tested positive for the drug she reported consuming, but could not produce a prescription for the drug, as her husband had given her one of his pills after she had strained her back—a technical case of illegal drug use.
7. **Contraband:** An even more direct violation of drug-free workplace policies involves bringing alcohol or other drugs and related contraband into the addiction treatment workplace. Thea's alcohol problem remained hidden until a secretary sent to retrieve a file found a bottle of bourbon in the back of a drawer in Thea's desk—a significant breach of agency policies prohibiting bringing contraband into the workplace.
8. **Substance Use/Misuse in the Community while Acting in One's Professional Role:** Brady was assigned to do a speaking engagement at a local service club, in which he provided an overview of his agency's addiction treatment services. The following day, the director received a call in which he learned that Brady had liberally availed himself of the open bar before he was due to speak, and that his words were slurred during his speech. This complaint reflects ways in which ATOD-related behavior in the limbo between personal and professional time can be problematic for workers and treatment organizations. The most frequent issues that arise in this area are related to behavior at professional meetings or conferences.
9. **Substance Use/Misuse in the Community on One's Own Time:** Mary is a 22-year-old recent college graduate who works in an adolescent addiction treatment program. As her supervisor, you have received several complaints that Mary has been seen drinking heavily at some of the most notorious "party bars" in your community. It has also come to your attention that Orville, a preventionist who has major responsibility for providing anti-tobacco education in the local schools, is smoking in public. Are these private behaviors or professional practice issues? These examples illustrate how the off-work behavior of individuals working in the addiction field can raise professional practice issues that affect the reputations of service workers, service organizations, and the larger field. Many addiction treatment organizations have codes of professional practice that explicitly define expectations in this area.
10. **Arrest/Conviction on a Substance-related Violation:** Andrew, an addictions counselor, was arrested in an undercover sting for solicitation of prostitution, and was charged with possession of marijuana at the time of his highly publicized arrest.
11. **Loss of Work Credentials:** Marty, a member of the maintenance staff at an addiction treatment organization whose duties involved driving, lost his driver's license due to a driving while under the influence conviction following his arrest during non-work hours. Beatrice, a nurse working in a detox unit, lost her nursing license following her conviction for forging prescriptions for narcotic drugs.
12. **Relapse of Person for Whom Recovery Status is Linked to Job Performance:** Felicia works as a recovery coach in a local addictions treatment program. The supervisor received a report from another staff person that Felicia was observed drinking over the weekend at a concert in a neighboring community. Felicia represents herself as having been in continuous recovery for the past three years. There are several issues here, including the potential effects of Felicia's apparent relapse on her own health and career and the effects that Felicia's behavior/status could have on her clients and on the organization. Multiple professional practice issues are evident in this vignette, including the issue of misrepresentation of credentials within a role in which stable recovery is a core credential.

In another example, Jeremy self-identified as a person in recovery when he was hired as an addictions counselor and has represented himself as being in recovery for eight years. When questioned about being seen consuming alcohol, Jeremy responds that alcohol was not the drug to which he was addicted, that he has no problem with alcohol, and that his recovery status is based on his last date of heroin use. The situation with Jeremy raises questions about secondary drug use for people in recovery and forces a deeper exploration of the very definition of recovery. There are no

universally accepted standards regarding what drugs are embraced within the definition of recovery, what constitutes a relapse, and when one is ethically bound to report ATOD use or related problems to one's supervisor.

13. **Dual Relationships:** A final example of nexus arises when relationships linked to one's past AOD use resurface in the treatment setting. Theresa, an addictions counselor, admitted to her supervisor a year ago that she had developed an addiction to cocaine. After taking a leave of absence to go through treatment, she returned in a non-service role and has recently returned to a counseling role. Today she recognizes among clients being admitted to treatment a person from whom she purchased cocaine several times.

These vignettes illustrate the wide variety of ways in which one's ATOD-related decisions can ripple into the arena of professional practice. Before offering guidelines relevant to these situations, we will explore ways in which personal ATOD decisions of addictions professionals can influence service relationships and the service process.

ATOD Use, Transference, and Countertransference

Transference is a term used to describe ways in which a client's experiences (feelings, perceptions, expectations, behavioral patterns) in his or her most significant prior relationships are projected into his or her relationship with the addictions professional. *Countertransference* is the term used to describe the total emotional reaction of the addictions professional to each client—responses that can involve projections from the therapist's own past relationships, the therapist's beliefs about the client, his or her feelings for the client, and his or her overall attitude toward the client (Imhof, 1991; Imhof, Hirsch, & Terenzi, 1983). Countertransference is composed of both collective sentiments (those based on categorical responses to such issues as race, gender, age, sexual orientation, type of AOD use) and idiosyncratic sentiments (those based on unique emotional reactions of the counselor to a particular client). In psychoanalytic thinking, the manner and degree to which these transferences and countertransferences are actively managed exert a profound influence on the outcome, good or bad, of the helping process. The addictions professional's own ATOD-related attitudes and behaviors elicit transference responses from clients, and each client's unique ATOD-related behaviors and lifestyle elicit feelings from the addictions professional that can help or hinder the helping process.⁵ In this section, we will explore how one's own ATOD-related history and current ATOD use decisions can influence one's service relationships.

In 1963, Dr. Henry Krystal suggested an important proposition:

Since the therapist is his own working tool, he must be freed from blind spots and inhibitions. Only in this way can he make constructive use of his countertransferences, rather than have them disturb the treatment, or his own life, or both (Krystal & Moore, 1963, p. 711).

Knowledge of addiction and recovery is a critical competency of addiction counselors. Such knowledge and its effective use have not been found to be contingent upon recovery status, and the effects of the counselor's past or present ATOD use have not been a subject of focused study in the field. Historically, we have focused on recovery status and length of sobriety for individuals seeking to work in the field because of the close nexus between this status and the mission of the field, but the broader spectrum of ATOD use status has not been a visible issue.

There are many things that combine with ATOD use patterns to affect counselors' credibility and their service relationships. Differences in credibility and effectiveness, for example, could be compared across several subgroups of clinicians, including:

- Persons in recovery with educational preparation,
- Persons in recovery without educational preparation,
- Persons with no personal recovery experience, but with addiction and recovery experience within their families,

⁵ One's ATOD history and decisions can also influence the clinical supervision relationship (See Culbreth and Borders, 1998).

- Persons with no personal recovery experience, with addiction experience in their families, but with no recovery experiences in their families,
- Persons with no personal recovery experience with educational preparation,
- Persons with no personal recovery experience and no educational preparation, and
- Persons with no personal recovery experience, but who are developing or are now experiencing AOD-related problems.

The closest we have come as a field to identifying such subgroupings is a Michigan study (Stoffelmayr, Mavis, & Kasim, 1998) that surveyed 634 staff members of 51 treatment programs and found that 44% of respondents identified themselves as non-recovering, 30% as recovering, and 26% as not recovering but part of a family that had experienced addiction or recovery.

The effect of past or current ATOD use on clinical effectiveness remains a question ripe for theoretical speculation and scientific study. As a close observer of this issue for nearly four decades, I would offer the following observations about how our past or current ATOD use experiences can enter into our service relationships.

A counselor's history of living in environments without ATOD-related problems and the ability to control his or her own ATOD relationships may convey either incomprehensibility (at best) or an air of superiority and condescension (at worst) to clients who lack volitional control over such relationships. The potential of such attitudes to disrupt treatment led Howard and Hurdum to make the following declaration in 1940:

It is essential that complete abstinence be advised to the patient. Accordingly it is advisable that the therapist himself abstain, lest his acts or attitude seem to imply "you must not drink, but it is all right for me to do so as I am a superior person" (Howard & Hurdum, 1940, p. 357).

Not everyone would agree with this admonition, but the observation of Howard and Hurdum underscores subtle ways in which the therapist who has no history of ATOD problems can inadvertently express contempt toward those who do. One factor that historically distinguishes addictions professionals from other service professionals who interact with those with severe AOD problems is a service relationship based on moral equality and emotional authenticity (White, 2004b). But as we shall see, recovery alone does not ensure such a relationship, nor does lack of recovery status prevent one from developing such a relationship.

Counselors with past and current moderate ATOD relationships may also tend to expect or try to cultivate in their clients the same type of rational control over ATOD consumption that has worked successfully in the counselor's life. There is nothing in the normal user's experience that will provide an understanding of the addicted client's loss of volitional control over the timing, location, quantity, and consequences of ATOD use.

Jerome was hospitalized via the emergency room for unbearable pain (self-described as "a knife being pulled across my abdomen") related to acute alcoholic pancreatitis. He was heavily medicated with narcotics for more than two weeks before his condition stabilized enough to consider discharge. Each day of his stay, his physician and nurses communicated to him that this intense pain would return every time he drank. Upon his discharge, Jerome went to his car, reached for the bottle under his seat, and began drinking. He was readmitted before he ever left the hospital grounds.

For those who haven't experienced addiction close up, such behavior can be completely inexplicable and result in frustration and anger at the client's continued self-destruction, the therapist's emotional disengagement from the service relationship, and "therapeutic discharge" of the client for what appears to be willful recalcitrance.

Those workers with developing or unacknowledged ATOD problems may tend to underestimate the severity of ATOD problems in others as a way of minimizing their own emerging problems or try to work out these emerging problems via their clinical work with clients (McInerney, 1973). This underscores the need for service professionals who use psychoactive drugs of any kind to make regular effort to evaluate the effects of such use on their own lives and on their professional work with others. The goal in suggesting this is not a masked attempt to sober up the entire addictions treatment workforce. It is intended to prevent the spillover of personal ATOD issues into the addictions professional's service relationships. There is little doubt, for example, that the widespread addiction of the treatment workforce to

nicotine has dramatically slowed the process of acknowledging and assertively treating nicotine dependence within addiction treatment programs and fueled myths that supported this delay (e.g., the myth that quitting smoking and quitting drinking at the same time increases the risk of relapse).

Counselors (those without and even those with addiction histories) may unconsciously act out social and professional stigma linked to addiction, making assumptions based on misguided stereotypes and conveying feelings of contempt toward persons with certain drug choices and addiction-related lifestyles. Such contempt can arise from the social values one has learned as a member of this culture or through one's past experiences with these issues, either personally or in one's own family and social network. Counselors in recovery may respond to the internalized stigma associated with their addiction/recovery status through competition and conflict with other professionals, overcompensation (excessive hours), over-identification with clients, estrangement from their own recovery support groups, and relapse (Blume, 1977).

As noted earlier, those without ATOD histories who become addictions professionals can bring attitudes and subtle behaviors that signal an air of moral superiority to clients. The same can occur among those with addiction backgrounds. It is important to remind oneself of the strange pecking order within cultures of addiction through which members of each group elevate themselves by castigating those in other groups. Historically, "alkies" and "junkies" held each other in mutual contempt, and even the classic junkie world had a status order ranging from the "gutter hype" to the "righteous dope fiend." The point to be made here is that the prior positions one held and the attitudes endemic to those positions can be inadvertently brought into one's later career as a counselor.

Counselors in personal recovery from severe drug dependence can be particularly prone early in their counseling careers to see all AOD problems through the addiction lens. In this case, their abstinence becomes a distorting lens that sees all use as addiction and any failure to admit an ATOD problem as the "disease of denial." Some recovering counselors may also be prone to program the recoveries of those with whom they are working through the counselor's own narrow band of recovery experience.

This is a good time in our discussion to reaffirm the obvious: recovery status or abstinence by itself is not an addiction counseling credential—an insight recognized very early in the modern history of addiction counseling.

The former problem drinker, however, who controls his drinking on the basis of his A.A. activities, but who has not discovered and effectively worked through his own emotional problems, is in a worse position to function as an individual therapist to the alcoholic than a person without a history of alcoholism in the past but with no experience (Krystal & Moore, 1963, p. 710).

A person who after some years of sobriety still attends AA seven nights a week has not yet learned to play, relates poorly to the opposite sex and to family, and has little interest in anything other than alcoholism. Such a person is scarcely an ideal candidate [for the role of alcoholism counselor] (Bissell, 1982, p. 811).

I would add to Krystal and Bissell's observations that, even for the most fully actualized person in recovery, recovery status alone is not a sufficient foundation for addiction counseling.

All ATOD-related decisions and experiences constitute potential sources of bias. For example, where counselors in short-term recovery are prone to work out their own immediate recovery issues through their clinical work with clients, I have observed counselors in long-term recovery reaching a point of detachment from their addiction histories, losing their capacity for empathic identification, developing an air of moral superiority, and exhibiting great intolerance of and anger toward the actively addicted. This is analogous to highly successful minority group members who exhibit great contempt for those within their own ethnic group who exemplify racially stereotyped behavior.

There are several ways in which the addictions professional's ATOD use can influence clients, e.g., what the client observes or hears from others about the counselor's ATOD-related behavior, what the counselor tells the client about such behavior, or what the client senses or suspects about such behavior. One of the most obvious ways is through the behavior modeled by the service professional. Clients can share or take on a counselor's current addictive behavior and use the counselor's behavior to justify addictive thinking and behaviors (e.g., "if it's okay for my counselor to smoke, it's okay for me to smoke"). The most direct way in which the counselor's own ATOD history influences the client and others is through the act of self-disclosure of past or current ATOD experiences.

The Ethics and Etiquette of ATOD-related Self-disclosure

There are several rationales for counselor self-disclosure in the addiction treatment arena. Such disclosures can be aimed at lowering resistance, enhancing engagement, diminishing isolation and shame, enhancing hope, and illustrating particular problem-solving strategies. Self-disclosures are less in vogue today as a result of the professionalization of addiction counseling. Volunteering information or responding to questions about one's past or current ATOD experiences is a potentially troublesome area best sorted out within the larger context of the ethics of all self-disclosure in the clinical setting. The most significant issues related to counselor self-disclosure include problems of:

- lost focus, e.g., disclosures that divert the interview from the experience of the client to the experience of the counselor;
- inappropriate timing, e.g., disclosures that slow the development of or abort the therapeutic relationship;
- duration, e.g., disclosures of excessive length that constitute a form of introspective disengagement on the part of the counselor;
- immediacy, e.g., communicating current experiences from the counselor's personal life about which the counselor lacks objectivity and emotional control;
- inappropriate levels of intimacy, e.g., excessively intimate disclosures that diminish a client's feelings of physical and psychological safety in the service relationship or diminish the client's confidence in the abilities of the counselor; and
- cultural violation, e.g., disclosures that violate cultural etiquette.

There are also problems that can arise related to counselor disclosures of past or current ATOD use in professional settings (e.g., as a professional trainer), during presentation to the public, or in interviews with the media. The problems that arise related to trainer self-disclosure are very similar to those noted above that can occur in the counseling relationship, but public and media disclosures can be more complicated. I have had many experiences with the media, some quite positive and others that I thought would be at a PBS level that turned out to be closer to tabloid TV. The problems related to media are numerous and include programs that:

- victimize clients by emotionally exploiting their pain to elevate viewer, listener, or reader ratings;
- undermine personal recovery by asking questions that, if answered, would violate recovery support group membership guidelines (e.g., A.A. Traditions);
- contribute to stigma by focusing on sensational aspects of addiction that inflame fear and prejudice while failing to tell the recovery story fully;
- misrepresent by omission or distortion treatment methods and scientific data on treatment outcomes; and
- misrepresent by omission or distortion the diversity of pathways to recovery.

Participating in such practices undermines rather than elevates the field's service mission. Counselors also need to avoid serving as intermediaries in enticing clients to participate in media exposure primarily intended for purposes of program marketing.

Up in Smoke: Tobacco Addiction and the Addictions Professional

No ATOD-related issue generates more emotion right now than the issue of smoking as a professional practice issue or proposals for changes in organizational smoking policies in addiction treatment institutions. The nexus between personal nicotine addiction and professional performance is so great that smoking for those working in prevention and treatment will likely become a tragic and ironic artifact within the history of the field. The evidence supporting this shift is overwhelming.

The Factual Case Against Tobacco

1. 60 million Americans are addicted to tobacco (McGinnis & Foege, 1999).
2. 446 million Americans die each year of tobacco-related diseases, compared to 105,000 from alcohol abuse and alcoholism and 39,000 from other addictive drugs (McGinnis & Foege, 1999).
3. Early onset of smoking and heavy smoking are highly correlated with the subsequent development of other substance use and psychiatric disorders (Degenhardt & Hall, 2001).
4. Heavy smokers have more severe substance use disorders than do non-smokers and more moderate smokers (Marks, Hill, et al., 1997; Krejci, Steinberg, et al., 2003).
5. Between 85% and 95% of people admitted to addiction treatment in the United States are dependent upon tobacco—more than triple the national average (Bobo, 1992; Abrams et al., 1996; Burling & Ziff, 1988).
6. People with alcohol problems exhibit more severe nicotine addiction than do smokers without alcohol problems (Batel, Pessione, et al., 1995; Toneatto, Sobell, Sobell, & Kozlowski, 1995), are less likely to stop smoking (Hays, Schroeder, et al., 1999), and, as a result, bear a greater burden of nicotine-related diseases and deaths.
7. Those with more severe nicotine dependencies have poorer outcomes for the treatment of other drug dependencies (Patkar, Vergare, et al., 2003; Hillemacher, Bayerlein, et al., 2006); continued smoking following treatment for other drug dependencies increases the risk of relapse (Sobell, Sobell, & Kozlowski, 1995).
8. In alcoholism treatment programs in which smoking is not addressed, smoking cessation rates are very low (e.g., 3%) following discharge from treatment (Sobell, Sobell, & Agrawal, 2002).
9. Smoking-related diseases are a major cause of death for people who have successfully recovered from alcoholism/other drug dependence. Of those discharged from alcoholism treatment, more will later die from nicotine-related diseases than from alcohol-related diseases (Hurt et al., 1996).
10. The development of nicotine dependence by non-smokers during and following addiction treatment may constitute a harmful side-effect of such treatment as it is currently designed (Friend & Pagano, 2004).
11. Staff perceptions that most people admitted to addiction treatment do not want to stop smoking are challenged by surveys finding that most patients have a desire to stop smoking (Irving, Seidner, et al., 1994; Joseph, Nelson, et al., 2003), including those with co-occurring psychiatric illnesses (Unrod, Cook, et al., 2004).
12. Recovery rates are not compromised (and in fact are enhanced) when nicotine addiction is treated concurrently with other addictions (Bobo, McIlvain, et al., 1998; El-Guebaly, Cathcart, et al., 2002; Joseph, Nichol, et al., 1993; Lemon, Friedmann, et al., 2003; Sees & Clark, 1993).
13. Smoking cessation interventions provided during addiction treatment increase the rates of long-term abstinence from alcohol and illicit drugs by as much as 25% (Stuyt, 1997; Prochaska, Delucchi, et al., 2004).
14. Recovery from alcoholism increases the probability of successful cessation of nicotine addiction (Breslau & Peterson, et al., 1996).
15. No-smoking policies in addiction treatment programs do not decrease admissions or increase discharges against medical advice or administrative discharges (Hurt & Slade, 1990).
16. The scientific evidence overwhelmingly supports encouraging and assisting smoking cessation for individuals in recovery from other addictions (Sees & Clark, 1993; Sussman, 2002).
17. Staff who continue to be addicted to nicotine constitute a major obstacle to the reform of smoking policies in addiction treatment programs and the revamping of clinical philosophies and procedures related to nicotine addiction in such settings (Psychiatric News, August 4, 2000 ; Falkowski, 2003).⁶

⁶ I would like to acknowledge the assistance of Jason Schwartz in conducting this literature review.

Moving forward to address nicotine addiction within the larger rubric of addiction treatment is no longer a question of inadequate research; it is a question of honesty, courage and leadership.

Every day, addictions professionals who have been addicted to nicotine are shedding that addiction and embracing a personal manifesto containing one or more of the following propositions.

Nicotine: A Personal Manifesto	
I choose to:	I refuse to:
Forever sever my personal relationship with nicotine; it no longer has a place in my life.	Contribute money to or accept money from a predatory industry that has consciously sacrificed the health of the public for corporate profit.
Help hasten the end of the addiction field's enabling of tobacco addiction among our clients and our workers.	Remain silent about the tobacco industry's targeted marketing to women, children, communities of color, and citizens of developing countries.
Model responsible decision-making regarding all psychoactive drugs and encourage my clients and peers to do the same.	Model a behavior (smoking) that could take years from my own life and the lives of those who could be influenced by my example.
Offer assistance to those seeking to recover from nicotine addiction.	Live the hypocrisy of being addicted while working as an addictions professional.

Guidelines for ATOD Decision-making

ATOD use by addictions professionals is an issue with a long history that continues to be marked by complexities, ambiguities, and a lack of professional consensus. It remains an issue that can rapidly explode, injuring professional careers, service consumers, service organizations, and the broader professional arena in which we work. For the past four decades, I have been called upon to offer advice to individuals and organizations regarding these issues. The wisdom drawn from the history of the field and from my experience as an elder in this field is best summarized in the following guidelines. I offer them with a deep appreciation that others may extract different lessons from this history, and that lessons learned from the experiences of one generation may or may not be applicable to the changing contexts of the next.

1. Respect the fishbowl effect that accompanies work in all status- and stigma-laden fields. Remain cognizant of how your behavior in "off hours" influences the ways in which you and your organization are perceived within your community, and how such perceptions influence policy makers and current and potential service consumers.
2. As a professional leader, seek not a life of perfection, but a life of reasonable congruence between the field's core values and your daily conduct. Leaders and visible members of social movements involving stigmatized social issues have no rights to privacy, only decisions and behaviors that help or hurt their causes.
3. Filter decisions related to disclosure of your ATOD use history, your recovery status, and your pathway(s) of recovery initiation and maintenance through the values of honesty (tell the truth), discretion (protect your privacy), and, for those in Twelve Step recovery, the tradition of anonymity at the level of press.

4. If you are in recovery, cultivate and sustain mechanisms of recovery maintenance separate from your professional life. Working in service roles within the addictions field is not a viable program of personal recovery and may even undermine defense structures that have previously served to maintain sobriety.
5. Rigorously evaluate your own past or current relationships with ATODs, their role in your decision to work in the addictions field, and the congruence or incongruence between those relationships and your service responsibilities. Filter your ATOD use decisions through those ethical values that have long guided professional service relationships: competence, honesty, fidelity, loyalty, non-maleficence, and self-interest.
6. Use your personal/family ATOD-related history and your broader life experiences to enhance mutual identification and acceptance in the service relationship, convey hope and encouragement, and model skills essential to recovery self-management. Exemplify as best you can such core recovery values as self-acceptance, honesty, humility, gratitude, forgiveness, tolerance, and service.
7. If you drink alcohol, use discretion related to when, where, and under what circumstances you drink; the amount you drink; and how you conduct yourself while drinking (“the night has a thousand eyes”). If you drink alcohol, drink within the limits of healthy drinking established by the National Institute on Alcohol Abuse and Alcoholism⁷, and NEVER, NEVER drive after having consumed ANY alcohol.
8. If you work within an organizational culture that promotes excessive ATOD consumption, cultivate an outside-of-work support system to neutralize the influence of that culture, develop a sobriety-based support network within this setting, and explore relocation to a healthier organizational environment.
9. If you are consuming over-the-counter or prescription drugs with psychoactive effects or side effects, communicate this status to your clinical supervisor and/or a trusted professional peer, with the request that they help monitor your performance for any untoward effects.
10. If you are in recovery and have resumed ATOD use, you have a professional responsibility to immediately report this change in status to your clinical supervisor; evaluate the effect of this changed status on your clinical performance; and seek immediate help to prevent future harm to yourself, your clients, your organization, and the integrity of the field.⁸
11. If you wish to return to the field after having relapsed while working as an addictions professional, your chances are best if you demonstrate your willingness to meet the highest standards of supervision, e.g., your willingness to: 1) re-enter the field on a probationary status, 2) accept any requested limitation of duties, 3) participate in a formal impaired professionals treatment program, 4) provide random urine drops, 5) provide verification of counseling participation, 6) provide verification of participation in recovery mutual aid meetings, and 7) have a professional peer mentor.
12. If you are using illicit drugs, evaluate the potential effects of such use on those to whom you are personally and professionally accountable. If you value such use more than those to whom you are professionally accountable, seek an expert evaluation of your relationship with these substances or seek employment outside the specialty addictions field. Failure to take those actions is a violation of your fiduciary pledge to this field and the needs of its service constituents.
13. Adhere to all current legal, professional, and organizational standards related to ATOD use.
14. Immediately declare to your supervisor any pre-existing relationship with a potential or admitted client (or a client’s family member) with whom your past AOD use or related activities could affect the client’s feelings of safety and comfort receiving services at your organization.
15. Remain cognizant of how your reasons for using ATOD influence your attitudes toward, relationships with, and biases related to treatment goals and methods for each client. If you abstain from ATOD, remain aware of the ways in which either the reasons for that abstinence or your particular pathway and style of recovery might positively and negatively influence your work with clients, professional peers,

⁷ The NIAAA standard is for women to drink no more than one drink per day (total of seven drinks per week) and for men to drink no more than two drinks per day (total of fourteen drinks per week) (Dufour, 1999).

⁸ This is not an arbitrary standard applied to those in recovery. I have argued elsewhere (White & Popovits, 2001) that any change in one’s personal life that could significantly affect one’s clinical work should be reported and processed in clinical supervision.

and the community. Use clinical supervision to identify negative transference and countertransference before such feelings are acted out destructively by you or your client.

16. If you are addicted to nicotine and working as an addictions professional, you have a responsibility to initiate and sustain recovery from that addiction, and to keep seeking personal/professional support until that goal is achieved permanently.
17. Disclose your past or present ATOD experiences and decisions with clients only if that disclosure is clinically strategic, brief, appropriate for the developmental stage of the service relationship, and restricted to past material over which you have emotional control.
18. Beware of stigma pimps from the media who exploit stereotypes and fear for their own personal glorification and profit. Take risks with self-disclosure at the level of press only with individuals and programs that have an established track record of professionalism and respect.

The ultimate mandate for addictions professionals is to conduct their personal and professional lives in a manner congruent with the service mission they have chosen. These suggestions are offered, not as the last word on this subject, but as a stimulus to future dialogue on this important professional practice issue.

In closing, I also find it important to note what I have chosen not to address in this essay. The boundaries of the concept of addiction have eroded considerably, both in the addictions field and in the popular culture. At a professional level, an ever-widening range of excessive relationships with work, money, food, sex, risk, religion and the Internet are being embraced within the rubric of addiction. In the latter, people speak of being addicted to everything from chocolate to golf. This over-extension of addiction from its precise biological origins to its use as a broad metaphor for behavior that is pleasurable, repetitive, and potentially life disrupting, while troubling and perhaps inevitable, has important implications for the future of professional practice in addiction counseling.

There will likely be a growing movement to expand the range of historically private behaviors regarding which those working in the addictions field will be held professionally accountable. When does a counselor weigh too much or too little to work in addiction treatment? When does an addiction counselor's visit to a casino on his or her own time become a professional practice issue? Does the counselor working 60 hours a week deserve an award for this behavior or an admonishment and referral to the employee assistance program? The list is potentially unending, and that is the point.

Professional service fields tend to mirror the problems of their service consumers. Yes, the addictions field has a historical propensity for black-white thinking and excessive behavior! We will need to manage this propensity actively if the conceptual boundaries of addiction continue to erode. Defining the nexus—the point of connection—between private behavior and professional performance will be a difficult task as the field continues to evolve and redefine itself.

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